



Provider Communication

Subject: Pharmacy: November 30, 2009 Update	Priority: High
Date: November 25, 2009	Message ID: ACSBNR11252009_2

Dear Providers,

System Downtime:

The SXC claims processing system will be unavailable due to planned maintenance on Wednesday, December 2nd, between 2:00-4:00 a.m. EST. Claims needing to be submitted during these periods should be held until the maintenance is completed. Georgia Medicaid apologizes for any inconvenience this downtime may cause.

Point-Of-Sale (POS) Claim Status Response:

As a reminder, please review the POS Claim Status Response for helpful messaging about your processed claim.

Covered Insulin Syringes & Pen Needles Product List:

For a complete and current list of covered insulin syringes and pen needles (including applicable Georgia Maximum Allowable Cost (GMAC) prices) please refer to www.ghp.georgia.gov → Provider Information → Pharmacy Services Overview → View Full Text → Other Pharmacy Documents → Covered Insulin Syringes and Pen Needles.

Prevacid[®] 24hr Over The Counter (OTC)

Prevacid[®] 24HR OTC is not covered by the Georgia Medicaid Fee-for-Service (FFS) Program

Coverage Changes In Seroquel[®] 25MG And 50MG Strengths – Effective 12/01/2009

Starting December 1st, 2009 low-dose Seroquel[®] (quetiapine) 25 mg and 50 mg, taken up to 50 mg/day alone, will no longer be covered for Georgia Medicaid Fee-for-Service (FFS) Members. There will be no disruption to a Member's prescription fills if the Member is using the 25 mg or 50 mg tablets in conjunction with other strengths of Seroquel[®] to make a total dose greater than 50 mg/day **or** with an antidepressant and/or other antipsychotic.



Coverage Changes In Prevacid® – Effective 01/01/2010

Starting January 1st, 2010, Prevacid® (lansoprazole) capsules will no longer have preferred status on the Preferred Drug List (PDL) for Georgia Medicaid Fee-for-Service (FFS) Members. Both Nexium® (esomeprazole) and Kapidex® (dexlansoprazole) are preferred agents for GA Medicaid FFS Members.

For a complete listing of the Preferred Drug List (PDL), go to www.dch.georgia.gov/pharmacy and select the “Preferred Drug Lists” option.

Prior Authorization (PA) requests should continue to be directed to the SXC Clinical Call Center at 1-866-525-5827.

Important Update

DCH Decision Document

Listed below are Preferred Drug List changes for the State of Georgia Fee-For-Service Medicaid and PeachCare for Kids Programs

EFFECTIVE NOVEMBER 1, 2009

As communicated in the past, DCH has a new rebate vendor, Goold Health Systems, working with the state to support our CMS and Supplemental Rebate programs. DCH has now concluded its analysis of supplemental rebate offers for the most recent round of bidding and PDL decisions for those categories involved in the bidding process are outlined below. **Those drugs highlighted in red indicate a change from current PDL status.** Several categories are up for discussion at the next Drug Utilization Review Board meeting and therefore they are not included in the decisions below. Those category decisions will be posted after DURB recommendations are received. Please note, this is not a full PDL listing and is not intended to include all covered drugs within a therapeutic category or provide a comprehensive list of therapeutic categories. For a full listing of our PDL, go to www.dch.georgia.gov/pharmacy and select the “Preferred Drug Lists” option.

DIABETIC - THIAZOL / BIGUANIDE COMBO			Effective Date: 11/1/09
	Preferred	Non-Preferred	
		ACTOPLUS MET TAB	
		AVANDAMET TAB	
		AVANDARYL TAB	
		DUETACT	
DIABETIC - THIAZOL			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	ACTOS 15MG	ACTOS 30MG, 45MG	
		AVANDIA	
GI - INFLAMMATORY			Effective Date: 11/1/09

BOWEL AGENTS			
	Preferred	Non-Preferred	
	ASACOL 400MG DR	ASACOL HD 800MG	
	PENTASA 250MG CR	PENTASA 500MG CR	
	CANASA	LIALDA	
	APRISO		
	SFROWASA		
GI - MISC.			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	MOVIPREP	HALFLYTELY	
	RELISTOR		
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS AND CALCIMIMETICS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	ZEMPLAR	SENSIPAR	
		HECTOROL	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-- TABS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	MAXALT-MLT	AMERGE	
	FROVA	AXERT	
	SUMATRIPTAN generic	MAXALT Tablet	
	IMITREX	MIGRANAL NS	
		RELPAX	
		TREXIMET	

		ZOMIG, -ZMT	
MUSCLE RELAXANTS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	DANTROLENE SODIUM	AMRIX	
		SKELAXIN	
		SOMA	
NARCOTICS - MISC.			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	VARIOUS GENERICS	FENTANYL ORAL	
	SUBOXONE	FENTORA	
	SUBUTEX	PRIMALEV	
		REPREXAIN	
		XOLOX	
		ZAMICET	
OP. BETA - BLOCKERS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	COMBIGAN	BETIMOL	
	BETAXOLOL HCL	BETAGAN	
	BETOPTIC-S	ISTALOL	
	CARTEOLOL HCL	TIMOPTIC, - XE	
	LEVOBUNOLOL HCL		
	METIPRANOLOL		
	TIMOLOL MALEATE		

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